

# EXHIBIT C

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must collect service-specific procedures and diagnosis data, to price specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintain detailed records of remittances to providers. The Contractor is responsible for annual IRS form 1099 reporting of provider earnings.

Management information systems capabilities are necessary for at least the following areas:

- Member enrollment
- Provider enrollment
- Third party liability activity
- Claims payment
- Grievance and complaint tracking
- Tracking and recall for immunizations, well-child visits/EPSTD, and other services as required by DCH
- Encounter reporting
- Quality reporting
- Member access and satisfaction

#### 5. Governing Body

Each Contractor will have a governing body that has a minimum of 1/3 of its membership consisting of adult Enrollees who are not compensated officers, employees, stockholders who own more than 5% of the shares of the Contractor's plan, or other individuals responsible for the conduct of, or financially interested in, the Contractor's affairs. The Contractor must have written policies and procedures detailing how Enrollee board members will be elected, the length of the term, filling of vacancies, notice to Enrollees and subscribers, etc. The governing body will ensure adoption and implementation of written policies governing the operation of the Contractor's plan. The Enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan. The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor will be responsible to the governing body. The governing body must meet at least quarterly, and must keep a permanent record of all proceedings that is available to DCH and/or HCFA on request.

#### 6. Provider Network in the CHCP

##### (a) General

The Contractor is solely responsible for arranging and administering Covered Services to Enrollees. Covered Services shall be medically necessary and administered, or arranged for, by a designated PCP. Enrollees shall be provided with an opportunity to select their PCP. If the Enrollee does not choose a PCP at the time of enrollment, it is the Contractor's responsibility to assign a PCP within one month of the effective date of enrollment. If the Contractor cannot honor the Enrollee's choice of the PCP, the Contractor must contact the Enrollee to allow the Enrollee to either make a choice of an alternative PCP or to disenroll. The Contractor must notify all Enrollees assigned to a PCP whose provider contract will be terminated and assist them in choosing a new PCP prior to the termination of the provider contract.



The Contractor must ensure that the provider network:

- provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of Covered Services.
- guarantees that emergency services are available seven days a week, 24-hours per day.
- demonstrates that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of the enrolled Beneficiaries within each enrollment area.
- assures that contracted PCPs provide or arrange for coverage of services 24 hours a day, 7 days a week and PCPs must be available to see patients a minimum of 20 hours per practice location per week.
- responds to the cultural, racial and linguistic needs (including interpretive services as necessary) of the Medicaid population.
- is described in the provider files for PCPs and other providers that are submitted to the Department's Enrollment Services Contractor.
- will have sufficient capacity to handle the maximum number of Enrollees specified under this Contract.

Provider files will be used to give Beneficiaries information on available Contractors and to ensure that the provider networks identified for Contractors are adequate in terms of number, location, and hours of operation. The Contractor will ensure:

- that it will provide to DCH's Enrollment Services contractor provider files which contain a complete description of the provider network available to Enrollees;
- that provider files will be submitted in the format specified by DCH;
- that provider files will be updated as necessary to reflect the existing provider network;
- that provider files will be submitted to DCH's Enrollment Services contractor in a timely manner;
- that it will provide to DCH's Enrollment Services contractor a description of the Contractor's service network, including but not limited to: the specialty and hospital network available, arrangements for provision of medically necessary non-contracted specialty care; any family planning services network available, any affiliations with Federally Qualified Health Centers, Rural Health Clinics, and Adolescent Health Centers; arrangements for access to obstetrical and gynecological services; availability of case management or care coordination services; and arrangements for provision of ancillary services. The description will be updated as necessary;
- that the services network will be submitted to DCH's Enrollment Services contractor in a timely manner in the format requested

The Contractor will ensure:

- that selected PCPs are accessible taking into account travel time, availability of public transportation and other factors that may determine accessibility;
- that primary care and hospital services will be available to Enrollees within 30 minutes or 30 miles travel. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 minutes or 30 miles travel time. For pharmacy services, the State's expectations are that the Contractor will ensure access within 30 minutes travel time and that services will be available during evenings and on weekends;
- that reasonable access to specialists will be based on the availability and distribution of such specialists;



- that adequate access exists for ancillary services such as pharmacy services, durable medical equipment services, home health services, and Maternal and Infant Support Services;
- that arrangements for laboratory services will be through only those laboratories with CLIA certificates;
- that all ancillary providers and facilities must be appropriately licensed or certified if required under 1978 PA 368, as amended.

(b) Mainstreaming

DCH considers mainstreaming of Enrollees into the broader health delivery system to be important. The Contractor must have guidelines and a process in place to ensure that Enrollees are provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap. In addition, the Contractor must ensure that:

- Enrollees will not be denied a Covered Service or availability of a facility or provider identified in this Contract.
- Network providers will not intentionally segregate Enrollees in any way from other persons receiving health care services.

(c) Public and Community Providers and Organizations

Contractors must work closely with local public and private community-based organizations and providers to address prevalent health care conditions and issues. Such agencies and organizations include local health departments, local FIA offices, family planning agencies, Substance Abuse Coordinating Agencies, community and migrant health centers, school based and adolescent health centers, and local or regional consortiums centered around various health conditions. Local coordination and collaboration with these entities will make a wider range of essential health care and support services available to the Contractor's Enrollees. Each county has a different array of these providers, and agencies or organizations. Contractors are encouraged to coordinate with these entities through participation of their provider networks in Michigan's county-based community health assessment and improvement process and multipurpose human services collaborative bodies.

A local coordination matrix is provided in the Appendix of this Contract. The Contractor is encouraged to use this document as a guide for establishing coordination and collaboration practices and protocols with local public health agencies. To ensure that the services provided by these agencies are available to all Contractors, an individual Contractor shall not require an exclusive contract as a condition of participation with the Contractor.

It is also beneficial for Contractors to collaborate with non-profit organizations that have maintained a historical base in the community. These entities are seen by many Enrollees as "safe harbors" due to their familiarity with the cultural standards and practices within the community. For example, adolescent health centers are specifically designed to be accessible and acceptable, and are viewed as a "safe harbor" where adolescents will seek rather than avoid or delay needed services.



(d) Local Behavioral Health and Developmental Disability Provider Agreements

Some Enrollees in each Contractor's plan may also be eligible for services provided by Behavioral Health Services and Services for Persons with Developmental Disabilities managed care programs. Contractors are not responsible for the direct delivery of specified behavioral health and developmental disability services. The Contractor will establish and maintain local agreements with behavioral health and developmental disability agencies or organizations contracting with the State.

Contractors must ensure that local agreements address the following issues:

- Emergency services
- Pharmacy and laboratory service coordination
- Medical coordination
- Data and reporting requirements
- Quality assurance coordination
- Grievance and complaint resolution
- Dispute resolution

Examples of local agreements are included in the Appendix of this Contract.

(e) Network Changes

Contractors will notify DCH within seven (7) days of any changes to the composition of the provider network that affects the Contractor's ability to make available all Covered Services in a timely manner. Contractors will have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that DCH determines to negatively affect Enrollees' access to Covered Services may be grounds for sanctions or Contract termination.

If the Contractor expands the PCP network within a county and can serve more Enrollees the Contractor may submit a request to DCH to increase capacity. The request must include details of the changes that would support the increased capacity. Contractor must use the format specified by DCH to describe network capacity.

(f) Provider Contracts

In addition to HMO licensure requirements, Contractor provider contracts will meet the following criteria:

- Prohibit the provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the Contract and require the provider to look solely to the Contractor for compensation for services rendered. No cost-sharing or deductibles can be collected from Enrollees. Co-payments are only permitted with DCH approval.
- Require the provider to cooperate with the Contractor's quality improvement and utilization review activities.
- Include provisions for the immediate transfer of Enrollees to another Contractor PCP if their health or safety is in jeopardy.
- Cannot prohibit a provider from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor.



- Cannot prohibit a provider from advocating on behalf of the Enrollee in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.
- Require providers to meet Medicaid accessibility standards as established in Medicaid policy.

In accordance with Section 1932 (b)(7) of the Social Security Act as implemented by Section 4704(a) of the Balanced Budget Act, Contractors may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit Contractors from limiting provider participation to the extent necessary to meet the needs of the Enrollees. This provision also does not interfere with measures established by Contractors that are designed to maintain quality and control costs consistent with the responsibility of the organization.

(g) Disclosure of Physician Incentive Plan

Contractors will annually disclose to DCH the information on their provider incentive plans listed in 42 CFR 417.479(h)(1) and 417.479(i), as required in 42 CFR 434.70(a)(3), in order to determine whether the incentive plans meet the requirements of 42 CFR 417.479 (d) — (g) when there exists compensation arrangements under the Contract where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903 (s) of the Social Security Act. The Contractor will provide the information on its physician incentive plans listed in 42 CFR 417.479(h)(3) to any Enrollee.

(h) Provider Credentialing

The Contractor will have written credentialing and re-credentialing (at least every two years) policies and procedures for ensuring quality of care and ensuring that all providers rendering services to their Enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract. The Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state. The Contractor also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the Contractor's medical management standards.

(i) PCP Standards

The Contractor must offer its Enrollees freedom of choice in selecting a PCP. The Contractor will have written policies and procedures describing how Enrollees choose and are assigned to a PCP, and how they may change their PCP. The PCP is responsible for supervising, coordinating and providing all primary care to each assigned Enrollee. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of each Enrollee's health care, and maintaining the Enrollee's medical record which includes documentation of all services provided by the PCP as well as any specialty or referral services.

The Contractor will allow a specialist to perform as a PCP when the Enrollee's medical condition warrants management by a physician specialist. This may be necessary for those Enrollees with conditions such as diabetes, end-stage



renal disease or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the Enrollee. If the Enrollee disagrees with the Contractor's decision, the Enrollee should be informed of his or her right to file a grievance with the Contractor and/or to file an appeal with DCH.

The Contractor will ensure that there is a reliable method and system for providing 24 hour access to urgent care and emergency services 7 days a week. All PCPs within the network must have information on the system and must reinforce with their Enrollees the appropriate use of health care services. Routine physician and office visits must be available during regular and scheduled office hours. Provisions must be available for obtaining urgent care 24 hours a day. Urgent care may be provided directly by the PCP or directed by the Contractor through other arrangements. Emergency Services must always be available.

Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

At a minimum, the Contractor shall have or provide one full-time PCP per 2,000 members. This ratio shall be used to determine maximum Enrollment Capacity for the Contractor in an approved service area.

The Contractor will assign a PCP who is within 30 minutes or 30 miles travel time to the Enrollee's home, unless the Enrollee chooses otherwise. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 minute or 30 mile travel time. The Contractor will take the availability of handicap accessible public transportation into consideration when making PCP assignments.

PCPs must be available to see Enrollees a minimum of 20 hours per practice location per week. This provision may be waived by DCH in response to a request supported by appropriate documentation. Specialists are not required to meet this standard for minimum hours per practice location per week. In the event that a specialist is assigned to act as a PCP, the Enrollee must be informed of the specialist's business hours. In circumstances where teaching hospitals use residents as providers in a clinic and a supervising physician is designated as the PCP by the Contractor, the supervising physician must be available at least 20 hours per practice location per week.

The Contractor will ensure that some providers offer evening and weekend hours of operation in addition to scheduled daytime hours. The Contractor will provide notice to Enrollees of the hours and locations of service for their assigned PCP.

The Contractor will monitor waiting times to get appointments with providers, as well as the length of time actually spent waiting to see the provider. This data must be reported to DCH upon request. The Contractor will have established criteria for monitoring appointment scheduling for routine and urgent care and for monitoring waiting times in provider offices. These criteria must be submitted to DCH upon request.

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- A CONTRACTOR'S AWARDED PRICES
- B APPROVED SERVICE AREAS
- C CORRECTIVE ACTION PLANS (to be developed at a later date)



The Contractor will ensure that a maternity care provider is designated for an enrolled pregnant woman for the duration of her pregnancy and postpartum care. A maternity care provider is a provider meeting the Contractor's credentialing requirements and whose scope of practice includes maternity care. An individual provider must be named as the maternity care provider to assure continuity of care. An OB/GYN clinic or practice cannot be designated as a PCP or maternity care provider. Designation of individual providers within a clinic or practice is appropriate as long as that individual, within the clinic or practice, agrees to accept responsibility for the Enrollees care for the duration of the pregnancy and post-partum care.

For maternity care, the Contractor will be able to provide initial prenatal care appointments for enrolled pregnant women according to standards developed by the CAC and the QIC.

## **II-N PAYMENT TO PROVIDERS**

The Contractor will make timely payments to all providers for Covered Services rendered to Enrollees. With the exception of newborns, the Contractor will not be responsible for any payments owed to providers for services rendered prior to a Beneficiary's enrollment with the Contractor's plan. Except for newborns, payment for services provided during a period of retroactive eligibility will be the responsibility of DCH.

### **1. Electronic Billing Capacity**

The Contractor must meet the following timeframes for electronic billing capacity and may require its providers to meet the same standard as a condition for payment:

- (a) Be capable of accepting electronic billing for HCFA 1500 and UB 92 no later than May 31, 2000;
- (b) Be capable of accepting electronic billing for UB 92 (Inpatient and Outpatient Claims) with Medicare format standards no later than September 30, 2000;
- (c) Be capable of accepting electronic billing for HCFA 1500 claims with Medicare format standards no later than December 31, 2000.

### **2. Prompt Payment**

Contractors must meet the prompt payment requirements as stated in 2000 PA 187.

### **3. Payment Resolution Process**

The Contractor will have an effective provider appeal process to promptly resolve provider billing disputes. The Contractor will cooperate with providers who have exhausted the Contractor's appeal process by entering into arbitration or other alternative dispute resolution process.

### **4. Arbitration**

**EXHIBIT**

**E**

## Tab E



**HEALTH ANNUAL STATEMENT  
FOR THE YEAR ENDING DECEMBER 31, 2004**  
OF THE CONDITION AND AFFAIRS OF THE

**THE WELLNESS PLAN**

NAIC Group Code	<u>1150</u> <small>(Client Period)</small>	<u>1150</u> <small>(Prior Period)</small>	NAIC Company Code	<u>95471</u>	Employer's ID Number	<u>38-2008890</u>
Organized under the Laws of	<u>Michigan</u>			State of Domicile or Port of Entry	<u>Michigan</u>	
Country of Domicile	<u>United States of America</u>					
Licensed as business type:	Life, Accident & Health [ ]    Property/Casualty [ ]    Dental Service Corporation [ ] Vision Service Corporation [ ]    Other [ ]    Health Maintenance Organization [ X ] Hospital, Medical & Dental Service or Indemnity [ ]    Is HMO, Federally Qualified? Yes [ X ] No [ ]					
Incorporated	<u>11/08/1972</u>		Commenced Business	<u>02/28/1973</u>		
Statutory Home Office	<u>7700 SECOND AVENUE</u> <small>(Street and Number)</small>			<u>DETROIT, MI 48202</u> <small>(City or Town, State and Zip Code)</small>		
Main Administrative Office	<u>7700 SECOND AVENUE</u> <small>(Street and Number)</small>					
	<u>DETROIT, MI 48202</u> <small>(City or Town, State and Zip Code)</small>			<u>313-202-8500</u> <small>(Area Code) (Telephone Number)</small>		
Mail Address	<u>7700 SECOND AVENUE</u> <small>(Street and Number or P.O. Box)</small>			<u>DETROIT, MI 48202</u> <small>(City or Town, State and Zip Code)</small>		
Primary Location of Books and Records	<u>7700 SECOND AVENUE</u> <small>(Street and Number)</small>					
	<u>DETROIT, MI 48202</u> <small>(City or Town, State and Zip Code)</small>			<u>313-202-8500-27828</u> <small>(Area Code) (Telephone Number)</small>		
Internet Website Address	<u>www.wellplan.com</u>					
Statutory Statement Contact	<u>Rao Kakarala Mr.</u> <small>(Name)</small>			<u>313-202-8500-27828</u> <small>(Area Code) (Telephone Number) (Extension)</small>		
	<u>rkakarala@wellplan.com</u> <small>(E-mail Address)</small>			<u>313-202-6870</u> <small>(FAX Number)</small>		
Policyowner Relations Contact	<u>7700 SECOND AVENUE</u> <small>(Street and Number)</small>					
	<u>DETROIT, MI 48202</u> <small>(City or Town, State and Zip Code)</small>			<u>313-202-8500</u> <small>(Area Code) (Telephone Number) (Extension)</small>		

**OFFICERS**

Name	Title	Name	Title
<u>James Eric Gerber</u>	<u>Deputy Rehabilitator</u>		

**OTHER OFFICERS**

**DIRECTORS OR TRUSTEES**

State of Michigan                      SS  
County of Wayne

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

James Eric Gerber  
Deputy Rehabilitator

Subscribed and sworn to before me this  
24 day of February, 2005

Polly J. Jones  
Notary Public, Wayne County, MI  
August 17, 2007

- a. Is this an original filing?    Yes [ X ] No [ ]  
b. If no,  
1. State the amendment number \_\_\_\_\_  
2. Date filed \_\_\_\_\_  
3. Number of pages attached \_\_\_\_\_

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS**

(000 Omitted)

**Section A - Paid Health Claims - Hospital and Medical**

	Year in Which Losses Were Incurred					Cumulative Net Amounts Paid				
	1	2	3	4	5	1	2	3	4	5
1. Prior										
2. 2000			29,666			29,666				29,666
3. 2001			16,383				30,244			30,244
4. 2002							23,155			23,155
5. 2003							24,026			24,026
6. 2004								28,282		28,282
									15,688	15,688
										6,128

**Section B - Incurred Health Claims - Hospital and Medical**

	Year in Which Losses Were Incurred					Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
	1	2	3	4	5	1	2	3	4	5
1. Prior										
2. 2000			30,215			30,215				30,215
3. 2001			22,552				23,155			23,155
4. 2002							33,569			33,569
5. 2003								31,543		31,543
6. 2004									19,849	19,849
										6,229

**Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Hospital and Medical**

	1	2	3	4	5	6	7	8	9	10
Years in which Premiums were Earned and Claims were Incurred	Premiums Earned	Claim Payments	Claim Adjustment Expense Payments	Col. (6/2) Percent	Claim and Claim Adjustment Expense Payments (Col 2+5)	Col. (6/1) Percent	Claims Unpaid	Unpaid Claim Adjustment Expense	Total Claims and Claims Adjustment Expense Incurred (Col. 6+7+8)	Col. (9/1) Percent
1. 2000	0	0		0.0	0	0.0			0	0
2. 2001	25,319	31,079	401	1.3	31,480	124.3			31,480	124.3
3. 2002	26,072	29,785	735	0.5	29,920	114.8			29,920	114.8
4. 2003	18,079	17,239	61	0.4	17,300	95.7	951		18,251	101.1
5. 2004	4,474	6,128	78	1.3	6,205	138.7	101	8	6,315	141.1

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

(000 Omitted)

**Section A - Paid Health Claims - Medicare Supplement**

	Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		0	0	0	0	0
3. 2001			0	0	0	0
4. 2002				0	0	0
5. 2003					0	0
6. 2004						0

**Section B - Incurred Health Claims - Medicare Supplement**

	Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
		1	2	3	4	5
1. Prior						
2. 2000						
3. 2001						
4. 2002						
5. 2003						
6. 2004						

**Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Medicare Supplement**

	1 Years in which Premiums were Earned and Claims were Incurred	2 Premiums Earned	3 Claim Payments	4 Claim Adjustment Expense Payments	5 Col. (3/2) Percent	6 Claim and Claim Adjustment Expense Ratio (Col. 2-5)	7 Col. (6/1) Percent	8 Claims Unpaid	9 Unpaid Claim Adjustment Expense (Col. 8-7)	10 Total Claims and Claims Adjustment Expense Incurred (Col. 3+9) Percent
1.										
2.										
3.										
4.										
5.										

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS  
(000 Omitted)

**Section A - Paid Health Claims - Dental Only**

1. Prior	Year In Which Losses Were Incurred	Cumulative Net Amounts Paid				
		1 2000	2 2001	3 2002	4 2003	5 2004
2. 2000		0	0	0	0	0
3. 2001		0	0	0	0	0
4. 2002		0	0	0	0	0
5. 2003		0	0	0	0	0
6. 2004		0	0	0	0	0

**Section B - Incurred Health Claims - Dental Only**

1. Prior	Year In Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
		1	2	3	4	5
2. 2000		0	0	0	0	0
3. 2001		0	0	0	0	0
4. 2002		0	0	0	0	0
5. 2003		0	0	0	0	0
6. 2004		0	0	0	0	0

**Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Dental Only**

1. Years In Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claim Payments	3 Claim Adjustment Expense Payments	4 Col. (3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col 2+3)	6 Col. (5/1) Percent	7 Claims Unpaid	8 Unpaid Claim Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 Col. (9/1) Percent
2. 2000										
3. 2001										
4. 2002										
5. 2003										
6. 2004										

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS  
(000 Omitted)

**Section A - Paid Health Claims - Vision Only**

	Year In Which Losses Were Incurred	Cumulative Net Amounts Paid				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		0	0	0	0	0
3. 2001		0	0	0	0	0
4. 2002		III	0	0	0	0
5. 2003		III	III	0	0	0
6. 2004		III	III	III	III	

**Section B - Incurred Health Claims - Vision Only**

	Year In Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
		1	2	3	4	5
1. Prior						
2.						
3.		III				
4.		III	III			
5.		III	III	III		
6.		III	III	III	III	

**Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Vision Only**

	Years In which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claim Payments	3 Claim Adjustment Expense Payments	4 Col. (3)/2 Percent	5 Claim and Claim Adjustment Expense Payments (Col 2+3)	6 Col. (6)/1 Percent	7 Claims Unpaid	8 Unpaid Claim Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 Col. (9)/1 Percent
1.											
2.											
3.											
4.											
5.											

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

(000 Omitted)

**Section A - Paid Health Claims - Federal Employees Health Benefits Plan Premium**

	Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		0		50	50	50
3. 2001			48	522	522	522
4. 2002			1,270	1,708	1,708	1,708
5. 2003				1,762	1,940	1,940
6. 2004					1,604	1,769

**Section B - Incurred Health Claims - Federal Employees Health Benefits Plan Premium**

	Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		0	48	50	50	50
3. 2001			522	522	522	522
4. 2002			2,110	1,721	1,708	1,708
5. 2003				2,008	1,916	1,940
6. 2004					2,046	2,084

**Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Federal Employees Health Benefits Plan Premium**

	Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claim Payments	3 Claim Adjustment Expense Payments	4 Col. (3)/2 Percent	5 Claim and Claim Adjustment Expense Payments (Col.2+3)	6 Col. (5)/1 Percent	7 Claims Unpaid	8 Unpaid Claim Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col.5+7+8)	10 Col. (9)/1 Percent
1. 2000		0	0		0.0	0	0.0			0	0.0
2. 2001		1,954	1,708	31	1.8	1,739	89.0			1,739	89.0
3. 2002		1,862	1,940	10	0.5	1,950	99.4			1,950	99.4
4. 2003		1,910	1,769	5	0.3	1,775	92.9			1,775	92.9
5. 2004			0	5	0.0	5	0.0	315		320	0.0

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS  
(000 Omitted)

Section A - Paid Health Claims - Medicare

	Year in Which Losses Were Incurred					Cumulative Net Amounts Paid				
	1	2	3	4	5	1	2	3	4	5
1. Prior										
2. 2000	0	0	0	0	0	0	0	0	0	0
3. 2001		0	0	0	0	0	0	0	0	0
4. 2002			0	0	0	0	0	0	0	0
5. 2003				0	0	0	0	0	0	0
6. 2004					0	0	0	0	0	0

Section B - Incurred Health Claims - Medicare

	Year in Which Losses Were Incurred					Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
	1	2	3	4	5	1	2	3	4	5
1. Prior										
2. 2000										
3. 2001										
4. 2002										
5. 2003										
6. 2004										

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Medicare

	Year in Which Losses Were Incurred		Year in Which Losses Were Incurred		Year in Which Losses Were Incurred		Year in Which Losses Were Incurred		Year in Which Losses Were Incurred		Year in Which Losses Were Incurred	
	1	2	3	4	5	6	7	8	9	10	11	12
1. Prior												
2. 2000												
3. 2001												
4. 2002												
5. 2003												
6. 2004												

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

(000 Omitted)  
Section A - Paid Health Claims - Title XIX Medicaid

	Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		248,059	252,838	252,999	252,999	252,999
3. 2001			174,025	175,238	175,238	175,238
4. 2002		120,145	154,055	192,704	192,704	192,704
5. 2003				155,619	171,198	171,198
6. 2004					155,588	152,150
						117,171

Section B - Incurred Health Claims - Title XIX Medicaid

	Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		252,091	252,838	252,999	252,999	252,999
3. 2001			177,025	175,238	175,238	175,238
4. 2002		83,918	187,775	194,031	192,704	192,704
5. 2003				181,335	174,319	171,198
6. 2004					174,548	174,833
						128,122

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XIX Medicaid

	Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claim Payments	3 Claim Adjustment Expense Payments	4 Col. (3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col 2+3)	6 Col. (5/1) Percent	7 Claims Unpaid	8 Unpaid Claim Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 Col. (8/1) Percent
1. 2000		0	0	0	0.0	0	0.0			0	0.0
2. 2001		221,055	192,704	3,507	1.8	196,211	88.8			196,211	88.8
3. 2002		205,586	171,198	1,073	0.6	172,271	83.8			172,271	83.8
4. 2003		208,924	152,130	1,115	0.7	153,245	73.3	8,351	83	161,619	77.4
5. 2004		157,725	117,771	1,668	1.4	119,439	75.7	22,703	224	142,366	90.3

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
**PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS**  
 (000 Omitted)

		Section A - Paid Health Claims - Other				
		Cumulative Net Amounts Paid				
Year in Which Losses Were Incurred		1	2	3	4	5
		2000	2001	2002	2003	2004
1. Prior						
2. 2000		0	0	0	0	0
3. 2001		0	0	0	0	0
4. 2002		0	0	0	0	0
5. 2003		0	0	0	0	0
6. 2004		0	0	0	0	0

		Section B - Incurred Health Claims - Other				
		Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
Year in Which Losses Were Incurred		1	2	3	4	5
1. Prior						
2. 2000		0	0	0	0	0
3. 2001		0	0	0	0	0
4. 2002		0	0	0	0	0
5. 2003		0	0	0	0	0
6. 2004		0	0	0	0	0

		Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Other							
		1	2	3	4	5	6	7	8
		Premiums Earned	Claim Payments	Claim Adjustment Expense Payments	Col. (3/2) Percent	Claim and Claim Adjustment Expense Payments (Col.2+3)	Col. (6/1) Percent	Claims Unpaid	Unpaid Claim Adjustment Expenses
1. Years in which Premiums were Earned and Claims were Incurred									
2. 2000									
3. 2001									
4. 2002									
5. 2003									
6. 2004									

STATEMENT AS OF ANNUAL STATEMENT FOR THE YEAR 2004 OF THE THE WELLNESS PLAN

**UNDERWRITING AND INVESTMENT EXHIBIT**  
PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS  
(000 Omitted)

**Section A - Paid Health Claims - Grand Total**

	Year In Which Losses Were Incurred	Cumulative Net Amounts Paid				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		277,125	283,120	283,324	283,324	283,324
3. 2001			197,688	199,135	199,135	199,135
4. 2002				179,382	225,491	225,491
5. 2003					185,663	202,923
6. 2004						171,138
						123,899

**Section B - Incurred Health Claims - Grand Total**

	Year In Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
		1 2000	2 2001	3 2002	4 2003	5 2004
1. Prior						
2. 2000		282,306	283,120	283,325	283,324	283,324
3. 2001			200,703	199,135	199,135	199,135
4. 2002				227,004	225,491	225,491
5. 2003					214,896	202,923
6. 2004						195,107
						132,351

**Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total**

Years In Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claim Payments	3 Claim Adjustment Expense Payments	4 Col. (3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2+3)	6 Col. (5/1) Percent	7 Claims Unpaid	8 Unpaid Claim Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 Col. (9/1) Percent
1. 2000	0	0	0	0.0	0	0.0	0	0	0	0.0
2. 2001	248,328	225,491	3,939	1.7	229,430	92.4	0	0	229,430	92.4
3. 2002	233,622	202,923	1,218	0.6	204,141	87.4	0	0	204,141	87.4
4. 2003	228,913	171,138	1,182	0.7	172,320	75.3	9,302	83	181,705	79.4
5. 2004	162,199	123,899	1,751	1.4	125,650	77.5	23,119	232	149,007	91.9

STATE OF MICHIGAN  
CIRCUIT COURT FOR THE 30<sup>TH</sup> JUDICIAL CIRCUIT  
INGHAM COUNTY

In the Matter of:  
LINDA A. WATTERS, COMMISSIONER,  
OFFICE OF FINANCIAL AND INSURANCE SERVICES  
FOR THE STATE OF MICHIGAN

Petitioner,

-v-

File No. 03-1127-CR

THE WELLNESS PLAN,  
a Michigan health maintenance organization

Hon. William E. Collette

Respondent.

\_\_\_\_\_  
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**PROOF OF SERVICE**

Lori McKee states that on April 20, 2005, she served upon the following, by facsimile and by placing said document in an envelope, with full prepaid postage thereon and depositing same in a United States Mail receptacle located at 640 Griswold, Northville, Michigan 48167 to:

William A. Chenoweth  
Assistant Attorney General  
Insurance & Banking Division  
Williams Building  
525 West Ottawa Street  
Lansing, Michigan 48913  
facsimile (517) 335-6755  
one copy of the following documents:

Mark J. Zausmer  
Zausmer, Kaufman, August & Caldwell, P.C.  
31700 Middlebelt Road, Suite 150  
Farmington Hills, Michigan 48334  
facsimile (248) 851-0100

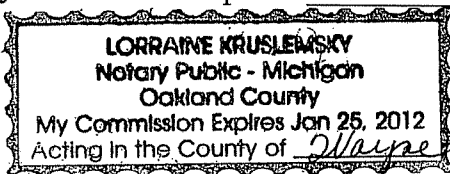
1. Brief Regarding Priority of Provider Claims for Purposes of The Wellness Plan Rehabilitation.
2. Proof of Service

Loei McKee  
Lori McKee

Subscribed and sworn before me  
this April 20, 2005

Lorraine Kruslemsky

Notary Public, Oakland County, MI  
My Commission Expires: 1-25-12



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